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ABSTRACT

The second of two transcripts from a radio series on learning disabilities (LD) presents interviews with educators, and LD adult, and physicians on such topics as problems of identifying LD students, stigmatizing labels, new tags for LD students, the need for additional teacher training, the relationship between LD and juvenile delinquency, hyperactivity, and the Feingold treatment. An annotated bibliography listing approximately 50 references is appended. (CL)

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Program No. 114: "LEARNING DISABILITIES"
PART II

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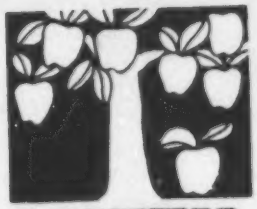

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Options in Education
TRANSCRIPT:

Program No. 114:

"LEARNING DISABILITIES"
PART II
March 27, 1978

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"LEARNING DISABILITIES"

PART II

CHILD: A...

CHILD: B...

CHILD: C...

MAN: D...

WOMAN: H...

MAN: I...

MAN: J...

CHILD: K...

MAN: L...

TEENAGER: M...

WOMAN: N...

WOMAN: O...

WOMAN: P...

MERROW: T-I-O-N-S -- options -- OPTIONS IN EDUCATION. From the ABC's of pre-school to the alphabet soup of government programs, this is OPTIONS IN EDUCATION.

* * *

BLAIR: I'm Wendy Blair.

MERROW: I'm John Merrow, and before this program is over, you'll need a blank piece of paper and a pencil.

BLAIR: A mirror too, John, don't forget the mirror.

MERROW: That's right. A piece of paper, a pencil and a mirror.

BLAIR: So if you'll get those three things, we'll go on about our business.

MERROW: This week, learning disabilities, a strange affliction or combination of afflictions which keep a lot of children from living up to their potential.

BLAIR: Here's an example.

AN EXAMPLE OF A LEARNING DISABLED STUDENT

KIRK: I was examining an 18-year-old boy the other day in front of an audience in a correctional institution. This boy couldn't read a primer. He had been in school for 10-15 years. And I said to him: "What is this word." "Sssh-oo." Now he couldn't put those together and tell me it was shoe. "What's this?" "Mmm-ee." He couldn't put those together to....Now, a four-year-old kid can do that, a five-year-old. He had no auditory synthetic ability, couldn't put sounds together.

BLAIR: Dr. Samuel Kirk of the University of Arizona describing one learning disabled child.

MERROW: Kirk, incidentally, is a key figure in the field of learning disabilities, and he says that only 1 or 2% of school-age children are learning disabled.

BLAIR: That means between half a million and one million kids.

MERROW: But other experts say that somewhere between 20 and 40% of our kids are learning disabled.

BLAIR: There's also disagreement about the term itself. What does learning disabled mean?

MERROW: It's easiest to tell you what it's not: not mentally retarded, not physically handicapped, not emotionally disturbed, not culturally disadvantaged.

BLAIR: Here's a common sense approach. An apparently bright child who does well in some things but not in others.

MERROW: Does well in reading but not in math, for example, or vice versa.

BLAIR: That child may well be learning disabled.

MERROW: Wendy said "may" for a good reason: there aren't any foolproof tests.

BLAIR: But despite all the uncertainty and confusion, there are good individualized teaching techniques that help learning disabled children overcome their problem, or compensate for it.

* * *

A LEARNING DISABLED STUDENT IN ROCHESTER, NEW YORK

STUDENT: After...this...said the tiger...uh...I should...of shawl...

HOWARTH: No, what's...

STUDENT: Ssh...what?

HOWARTH: What's short A say?

STUDENT: Aa.

HOWARTH: Ok. What's SH say?

STUDENT: Sssshaaall.

HOWARTH: Yeah. Say it again.

STUDENT: Ell.

HOWARTH: Put the SH on it.

STUDENT: Elsh...a...

HOWARTH: Look up here. Ssh. Short A says?

STUDENT: Aa.

HOWARTH: A, don't say it so far. Sha...

STUDENT: Sha...

HOWARTH: Sha...get in your mind.

STUDENT: Shaaaa...shall.

HOWARTH: Good. Shall.

STUDENT: Shall. Shall...eat...first...and...play the flute...later.

HOWARTH: Ok.

MERROW: Cathy Lewis of station WXXI recorded that learning disabled student with his teacher in Rochester, New York. He's in his teens, but is reading at about the third grade level. There are many other teenagers with learning disabilities, but most attention is focused on young children whose problems really don't show up till they start school. I asked Kris Glicken, a teacher of learning disabled kids in Naperville, Illinois, to describe one of the children she works with.

A TEACHER TALKS ABOUT HER WORK WITH LEARNING DISABLED KIDS

GLICKEN: Ok, I have a third grader right now who I've been working with for two years. He has repeated third grade since working with me. His main problem is spelling. He would spell words as basically consonants, no vowels, or he'd stick in vowels strange ways.

MERROW: You mean, he'd spell horse, h-r-s?

GLICKEN: T- maybe stick an O in there above the line. You know, just... it didn't make much sense. He...his daily writing could not be read. I've worked with...well, there's many methods that are questionable. You know, I've worked with him tracing letters, and I've worked with sound-symbol relationships and trying to bring in the visual memory for what he's reading. Basically, I'm trying to get him to understand a word and be able to break it down into parts, and hear the parts, and transfer what he has heard and what he knows in his brain into what he is writing. He's got to remember it that long. It seems a second to us, but it can be very long for some of these kids.

MERROW: And what kind of success are you having?

GLICKEN: Well, last year we worked, basically, on a small group of words I took word lists from the classroom to get him to be successful in the classroom. And their spelling test...Friday can be a very traumatic day for some of these children. Right now, we've been working on other words, words that children use in 60% of their daily handwriting. They're called lexical words: I, and, was, to, in, of.

MERROW: Can he spell those words?

GLICKEN: Yes. He's gotten...he's mastering about 75 to 80% of those words now. And also, you can just see in his daily writing that he is...he has gained an understanding for the sound-symbol relationship, and is able to sequence the sounds as they should be in a word.

MERROW: Is it possible that he is just compensating for the deficit; that he's learned enough about you and enough about those words that he's memorized those words and knows how to just regurgitate what he knows you're going to ask him to do?

GLICKEN: It could be if we were just dealing with those words. But I'm asking him to write a paragraph for me on his favorite animal, or anything. And these are words that I can't control. And he's able to come up with their spelling having not studied them.

MERROW: Now, what's wrong with him? What's his learning disability? Is there a name for it?

GLICKEN: I don't know if I can come up with it in a second, you know, because we're dealing with so many kids. But his breakdown is...I would

probably say auditory processing.

MERROW: Kris Glicken, a special education teacher in Naperville, Illinois, describing one of the learning disabled children she works with.

* * *

STUDENT: One...kind of...tiger...the...beginners...tiger...his he never been...tamed by...man. The...sss...tiger is a big...in...cats in the world.

* * *

BLAIR: A lot of children have learning problems, but that doesn't mean they have learning disabilities.

MERROW: There are tests, but the problems usually don't show up until the child begins school.

BLAIR: Barbara Bernhard talked to Dr. James Gallagher about the problems of identifying learning disabled children.

PROBLEMS OF IDENTIFYING LEARNING DISABLED CHILDREN

GALLAGHER: There have been a variety of tests that have been developed that are specifically designed to diagnose learning disabilities. Most of these try and identify the various skill areas, and to see if the youngster has special problems in those areas. For example, they'll have tests of auditory perception to see if their problem is that they can't decode the world around them through sound. They'll have visual decoding items that say: Is it that they are seeing things but they can't interpret what they see; or is it that they have problems with associating ideas with one another; that they see two things and everybody thinks they connect them up, but they really don't? So there are a variety of special tests; each one designed to identify those developmental areas that might be the problem. And on the basis of the kind of profile of results, of the strengths and weaknesses that the youngster shows on these kinds of tests, you then are able to judge many times what the major problem area is, and you can build a remedial program around that.

BLAIR: Dr. James Gallagher, Director of the Frank Porter Graham Child Development Center in North Carolina, talking with Barbara Bernhard of station WUNC, Chapel Hill, North Carolina.

MERROW: Identifying is one kind of problem; labeling is another. Some experts in the field are reluctant to call a child dyslexic, or to say that a kid suffers from minimal brain disfunction.

BLAIR: Why? Because they feel that labels stigmatize without helping treat the problem.

MERROW: Dr. Mario Pascale directs the Frostig Center for Learning Disabled Children in Los Angeles. I asked him for a list of the different kinds of learning disabilities, like dyslexia, aphasia and so forth.

LABELS STIGMATIZE LEARNING DISABLED CHILDREN

PASCALE: I'm reluctant to do that because I don't believe in those names. I don't believe in those kinds of labels that are used on children, because the label doesn't tell us anything more about the whole child. We're really talking about looking at a child from the whole point of view -- meaning his overall development -- and then there are these specific kinds of problems that may emerge. And oftentimes, when we use one of those commonly-used terms or labels, that doesn't answer the question, because the basic question is: What does the child need then to help him overcome the problem, and achieve to his full potential. So that a term like dyslexia, which is not an educational term, but it is a medical term, that means simply a reading disability; or discalcutia is another medical term that means a child is having problems with arithmetic reasoning and arithmetic skills. That doesn't answer the question, again, of what

kind of intervention, what kind of educational and/or medical program does that child need.

BLAIR: Dr. Mario Pascale, Director of the Frostig Center in Los Angeles, California.

MERROW: Don't label; treat the whole child; and work on a one-to-one basis whenever possible. Those are some of the ground rules, experts tell us.

BLAIR: That sounds like good teaching, John, for every kid, learning disabled or not.

MERROW: Kris Glicken, a teacher of learning disabled children in Naperville, Illinois, works with a dozen or so children every day.

BLAIR: She takes the learning disabled children out of the regular classroom and works with them in what is called a "resource room." But not everyone agrees that these children should get special treatment.

MERROW: Alan Forsythe, who's headmaster of the Carroll School, a private school, prefers not to accept learning disabled students into classes there. Dan Mack spoke with Forsythe at a meeting of the National Association of Independent Schools in New York City, and asked him: why not?

WHY ONE PRIVATE SCHOOL DOES NOT ACCEPT LEARNING DISABLED CHILDREN

FORSYTHE: Because it requires a very special type of program, structured program. These children don't learn at the same rate that the children...child without learning disabilities learns at, and because it's costly. Our ratio, for example, is five to one, student to faculty member, which is very costly for a private school.

MACK: What kind of rule of thumb do you use, if I can even use such a term, to determine what a learning disability is?

FORSYTHE: Well, our rule of thumb is to see if the child has average to above average IQ, and is lagging behind in basic skill areas by a year, two years, three years, and seems to have no physical or mental or emotional handicaps that are causing that learning deficit.

We're very technological, very literary...literate oriented society, and this is why we're running into more and more learning problems. People who had learning problems in the past, probably became farmers, factory workers, and this sort of thing. But the society is becoming too sophisticated for there to be a lot of positions. These are not stupid children; they are not unmotivated children; they are not emotionally disturbed. They have something in their brain, something in the neurological connections in the brain tha that just doesn't function like yours and mine does.

MERROW: Alan Forsythe, speaking with reporter Dan Mack in New York City

BLAIR: Dr. Samuel Kirk of the University of Arizona says that close personal attention, tutoring, is essential.

CLOSE PERSONAL ATTENTION IS ESSENTIAL FOR LEARNING DISABLED CHILDREN

KIRK: I did that for four years in an institution, and it was rather interesting that many of these children changed in personality because I gave them so much attention. I showed them success at every step, every day. And some of these children need intensive work. So, I say for the personnel that we have in learning disabilities, that each teacher take five or six or seven or eight children a day individually, in a resource room, or right in an itinerant way, and do intensive work with these children, and bring them up, and gradually fit them into a class if they can improve them, instead of trying to take 20,30 minor problems and get no place.

Let me give you just one case, to tell you what a real learning

disability child is. I ran a school for young mentally retarded children. They were diagnosed by pediatricians, psychologists; their IQs were low. There was something wrong with them at the age of four and five. I had one girl who had poor vision, nystagmus, classifed as legally blind, mentally retarded. They couldn't get her into an institution. When I looked her over, I found out she had fairly good vocabulary, higher than the IQ of 40 they gave me. But she couldn't see too well, because she had nystagmus and poor vision as a result of rubella. My diagnosis was, after trying her out, that she had poor speed of perception, which meant that if I showed her a picture of a chair, and I said to her, "Sharon, this is a chair," she said chair. And then I showed her another picture, and gave her the name, and then when I came back to chair, her eyes would jump, jump, jump, jump. And, you know, after a quarter of a second or so, she would say chair. Then I'd show her another picture, a little later she'd say...ball. In other words, her response to visual stimuli was very sluggish and very slow, probably due to the nystagmus.

I said, let's train her vision. We put her on a techistyscope, and we worked with her for six solid months, about a half hour a day. At the end of that time, she could respond to pictures in 1/25th of a second, very rapidly. At the same time, that transfer to the classroom, and this girl was able to tell us all kinds of things in pictures.

I had another child that couldn't understand anything. We had to do auditory training with her in the same way as we did visual training with this, and both of them came up. And by the age of six, six and a half, they went into school and succeeded. Maybe not as much as a normal child, but a long way from their original diagnosis. Those are the children we ought to be working with in learning disabilities, which we are not, because we devote much of our time to the minor problems in school, that I think the elementary teacher can handle.

MERROW: The stories you've just told indicate that those are physical problems at the basis of that learning disability. You had to work with a perception, speed up the perception, you had to work with auditory problems. Is that the case with most learning disabilities; that there's a physical basis for it?

KIRK: Many people infer that the brain isn't functioning properly with these children. Now, most of the time neurologists can't tell us why, but some of them with the VOCT potential and EEG's are trying to find the difficulty in the brain. As an educator, we're not going to wait until they've discovered what's wrong with the brain that causes the child that doesn't see fast, or that doesn't learn to read. We have to start with the child as is, and do the best we can in training him. Hopefully, some day, we will be able to diagnose brain function; we'll be able to find out what this brain function is doing to psychological response, and hopefully, set up an educational program to ameliorate or help this process. And maybe we can train the brain to work a little better in some way or another. So when we're able to connect education with psychology, with neurology, we'll have reached the ultimate. Today, there's a big gap between neurology and psychology. How do you explain psychological behavior from neurological functioning? How do you something educationally as a result of psychological defect? There are gaps all the way through.

BLAIR: Dr. Samuel Kirk of the University of Arizona. He says that professionals often assume that something's going wrong with the brain. But because so little is known about the brain, they can't prove it.

MERROW: Maybe the cause isn't all that important. What counts is changing the problem behavior: that is, teaching the child the blend sounds, or to see letters in the right order, or to coordinate the hand and eye movements. There's a lot of technology, machines, and supposedly psychologically appropriate toys, and so forth, on the market.

BLAIR: Many of these things were on display and selling at the Learning Disabilities Convention in Kansas City recently.

NEW TOYS TO HELP THE LEARNING DISABLED

MERROW: I'm at one of the exhibits here at the Learning Disabilities Convention. There are lots of exhibits around: textbooks, toys kids can play with. This one is...it sounds as if it's a record exhibit or something. You can hear that music in the background. But in fact, I'm creating that music, or I'm making that music play by what I'm doing with my hand. I'm writing with what's called a "talking pen." I'm following a black line. As long as I stay on the black line, you'll hear that music. As soon as I get off the line... This is a "talking pen." Now I'm back on the line and I'm learning...in this case I'm learning to make a circle. Some kids have trouble following the lines. Muscular difficulties, neurological problems. They may need something like this to help them learn muscular control. So this way, the cue, the auditory cue tells me that I'm not doing what I'm supposed to be doing, or in this case, I'm getting the positive reinforcement: I'm doing what I'm supposed to be doing. I can hear that music. And, again, as soon as I get off...a nasty little reminder to get back on the line. The inventor of the "talking pen" is Harry Wayne, and he's standing right here, so maybe I can talk to him.

WAYNE: Well, it can be connected to a radio or tape recorder, so that when we're on the pattern -- in this case it'll be quiet -- we go off the pattern, it can say, "Johnny, get back on the line." Or, we can reverse it so that it plays music when you're on the pattern; when you go off the pattern, it stops the music.

TALKING PEN: Get back on the line! You dummy dummy...dummy. Get back on the line. Dummy, dummy get back on the line.

MERROW: (Laughs) Ok.

WAYNE: Well, you wouldn't, of course, use "dummy." We're just trying to be dramatic here to illustrate that it can say, "Johnny, get back on the line," or it could be reversed: "Johnny, you're doing very well as long as you hear my voice."

MERROW: Who uses this?

WAYNE: Well, it's being used now all over the country. It's being used in the primary grades. That would be learning...working with children who have learning problems. It's being used in the adolescent...

MERROW: What kind of learning problems?

WAYNE: Ok. We're referring to children who have problems...whose motor development skills are lacking. The handwriting is usually poor; their eye-hand coordination is usually poor. We've suddenly become aware of these children existing. We sometimes...as a matter of fact, at times, some of them were even classified as retarded to an extent. But it was really the fact that they have poor developmental skills. And now, we're recognizing them, and we are working with these children. And now it is required, by law, that every public school take in a...take these children in and work with them in the public grades. And this is why the sudden interest, of course. There's a lot of funding for that purpose. We work with adolescents; we work with the...we do work with the mentally retarded, educatable mentally retarded. We work with the...in occupational therapy -- children who have affected muscles -- in developing muscle skills. We work with the visually impaired, the blind. We work with... we even work with autistic children.

MERROW: Harry Wayne of Skokie, Illinois, the inventor of the "talking pen," at the Learning Disabled Convention here in Kansas City.

BLAIR: The "talking pen," just one of the many items on the market that supposedly make it easier for learning disabled children to master basic tasks.

MERROW: Now here's another. You can have the voice cue also. Here it goes. Now I'm doing what I'm supposed to be doing, but as soon as I stop...

TALKING PEN: Back on the line. Dummy, dummy, dummy...dummy. Get back on the line. Dummy, dummy get back on the line...back on the line. Dummy, dummy...

MERROW: But technology may not be the answer. The key element in working with learning disabled children may be teaching.

BLAIR: And teachers come in for a lot of criticism, because, it's said, they're too quick to label kids just to get them out of the classroom and out of their hair.

THE NEED FOR ADDITIONAL TEACHER TRAINING

PASCALE: There's a need for, a massive need for revamping the preparation of regular classroom teachers at the level of pre-service, before they enter the field as teachers. And for those many more thousands of teachers that were not prepared in that way, we need to do the in-service training.

BLAIR: Dr. Mario Pascale, Director of the Frostig Center in Los Angeles.

MERROW: Re-training. That's the key, so that teachers will know what to do, and so that they will have some idea of what it's like to be learning disabled.

* * *

BLAIR: Now it's your turn to feel learning disabled. We asked you earlier to get a pencil, a small piece of blank paper, and a mirror.

MERROW: Here's what we want you to do. Hold the paper up against your forehead.

BLAIR: Now, look in the mirror.

MERROW: Take the pencil in your other hand and write the word "help" on the paper as you look in the mirror.

BLAIR: You can print it.

MERROW: In capital letters.

BLAIR: To make it a little easier.

* * *

MERROW: Finished? Any letters backwards? Upside down?

BLAIR: We know, because we took the test ourselves, that your writing is a mess!

MERROW: Let's do one more test. This time, with some accompanying encouragement from us.

BLAIR: This time, write your name. Same rules. Paper against your forehead looking in the mirror.

MERROW: Come on, work a little bit faster!

BLAIR: I don't think you're paying attention!

MERROW: Do you realize that everyone else in the class is finished!

BLAIR: I may have to send a note home to your parents about the way you dawdle. You've got to hurry up.

MERROW: I don't think you're really trying!

* * *

BLAIR: That was a little harder that time, wasn't it?

MERROW: Especially if your name is Frederick, or Catherine.

BLAIR: You're lucky, John.

* * *

MERROW: We took that example from a new book on learning disabilities by Dr. Alan O. Ross. It's called The Unrealized Potential.

BLAIR: The transcript of this OPTIONS IN EDUCATION program lists dozens of books you might want to refer to. We'll tell you how to get the transcript at the end of the program.

MERROW: Ross isn't the only one trying to help the rest of us understand what it's like to be learning disabled. I talked recently with two teachers from Augusta, Georgia, Cynthia Field and Kathy Lowe. They're trying to get classroom teachers in their state to feel what it's like to be learning disabled.

BLAIR: They make teachers try to draw optical illusions, then criticize them when they fail. Or, they give teachers a list of strange new symbols, and tell them to learn them...

MERROW: ...in five minutes.

BLAIR: And then give them a reading and spelling test in this "new language."

MERROW: Naturally, they all fail.

BLAIR: Cynthia Field and Kathy Lowe explained what they hope to achieve.

TEACHERS BECOME 'LEARNING DISABLED'

FIELD: We feel that this gives the teachers a feeling of what it's like. When we have students, particularly the older students, who open a history or a science textbook that's written on an eighth grade level, 12th grade level. They open it up; they read on a first or second grade level. It could be written in Greek for all the meaning that our students get. And this lets the teachers feel the same feelings our students do when they say, "Read the chapter!"

MERROW: What's your hypothesis? That most teachers don't empathize with kids who are learning disabled?

LOWE: We think that...that could be one hypothesis. We also feel like it's just the teachers have never been exposed to the feelings of these students, and, therefore, they don't understand them. Because a lot of LD students seem as if they're normal, and we hear, "Well, he can do it, he just...he won't." And when we find that it's more or less, sometimes, a lack of exposure and understanding of the problem that causes, you know, the hypothesis you just mentioned.

MERROW: Well now, you've got a whole bunch of frustrated teachers at the end of this presentation. They all hate you, or they're all frustrated, whatever. But are they supposed to change their behavior? Cynthia.

FIELD: Yes. We, we then go on to make the point that there are some things that they can do. And after we let them know how frustrating it is, we give them some things to do. We give them some very easy, not time consuming, things they can do, so that the students will be happy in their classroom and experience success, which will in turn make the teachers happy, because they

won't have these students creating problems in their room.

MERROW: Like what? What easy tasks do you give your teachers, whom you are teaching?

LOWE: We suggest to them that they cut a spelling list in half for a poor speller; that they don't make the student copy the whole sentence when it's fill in the blanks -- just write the word that goes in the blank; fold the paper in half so that the student isn't overwhelmed by a whole page of math problems at one time, and suggest that they just do one line at a time. Little things like that. Use highlighters and colored chalk. Make sure that the students understand the directions.

FIELD: As far as spelling too, we try to make sure a student is not asked to spell words that he can't read. And I think, after going through the reading lesson, this may carry over in the teachers' minds that how..."If I can't read that word, how on earth can it be easy for me to meaningfully spell the word and memorize it." Also, we try to give them suggestions for a lot of LD students who are very distractable and impulsive. They may be able to do the work that's assigned, but because of attending problems they can't. So we suggest that they help the student find a place in the room where he's comfortable working, where he doesn't have as many distractions. Sometimes using a study carrel, or getting behind a...maybe being on a rug and writing on a sheet of paper, or behind...in the back of the classroom, so that they're more or less away from the other students.

MERROW: These seem so elementary. Don't most teachers know these things?

FIELD: A lot of times we feel like they don't, or they would probably be trying these things. And I think part of the problem too is that they don't really realize that an LD student...that they have LD students who are causing the problem. Sometimes they may think they're just behavior problems, and I think that's part of the problem.

MERROW: And they're not just behavior problems. You...there's no question in your mind that these kids are LD?

FIELD: We feel there's a fine line, sometimes, between behavior disordered children and learning disabled children. But then you reach a question after several years, perhaps, depending on the age of the child, a frustration: what came first, the learning disability or the frustration. So, we feel like, basically, no. If these kids are catered to and their needs are met in school, that they will not be behavior problems generally.

MERROW: That's the...that phrase, that verb you use: "catered to." Is that...I think that maybe sticks in the craw of people outside school, saying, "What are you doing? You're just spoiling the kids."

FIELD: Right. Well, we feel like we're asking kids all to learn to read, many times, through the same method, and we try to teach people to be individuals in society and do what they want to do. So let's start carrying that over: we would like to do that in school in the way people learn differently. And a lot of times these kids are not...they're different because of their learning styles, not because of their interests and a desire to achieve.

MERROW: On that subject of "catering to," I used to teach in high school and in college. And I, particularly in high school, I do remember that impulse. That you think, "By golly, why should I treat that kid differently; why should..." especially when the kid is a pain. "Why should I bend over backward to do and set up what seems to be so special?" Do you understand that emotional response?

LOWE: Yes, I taught world history in a regular class, and I've been on the other side of the fence, and I know the frustrations. And I look back now

now on how I was then, and I think a lot of my attitudes were a lack of understanding and exposure to learning problems in classrooms as well. So, I feel like it's a normal feeling when you're not exposed to the type...when you're not put in the place of having a learning disability, feeling what it's really like.

MERROW: Cynthia Field and Kathy Lowe, two teachers from Augusta, Georgia, who try to make regular teachers understand what it's like to be learning disabled.

BLAIR: But teacher training alone isn't enough, according to Dr. James Gallagher.

THE NEED FOR MORE THAN TEACHER TRAINING

GALLAGHER: If you walk down the street and you pass a hundred people, one of them is likely to be an elementary or a secondary school teacher. So, when we're talking about...we're talking about one out of every hundred people in this country. So the chances are that not everyone of them is an expert on everything is very high. The question is can the school organize its resources to deal with this problem, not whether there's an individual teacher in George Washington School somewhere who is not doing everything that they should do. The question is you shouldn't plan your educational program as though this perfect person was going to be there. You plan it on the basis that there's a normal person that's going to be there, will make normal mistakes with their own limited skills and background, and that you have a system, however, that will help identify the youngsters that need help, and so you can do something about it. Too much is put on the individual teacher.

BLAIR: Dr. James Gallagher, Director of the Frank Porter Graham Child Development Center in North Carolina, talking with Barbara Bernhard, station WUNC, Chapel Hill, North Carolina.

MERROW: Rely on the system, Gallagher says, and take special care to provide the kind of help that's appropriate. Keep kids in the regular classroom if their problems are minor, but use resource rooms, or individual tutoring for children with serious learning disabilities.

BLAIR: Children get labeled because they're behind in learning. But behind what? Well, usually some age-related normal standard.

MERROW: But maybe the kids are just developing slowly: that is, they're perfectly all right, but just running behind biologically. Ellen Stone, President of the Naperville, Illinois Chapter of the Learning Disabilities Association, thinks that schools have to become more flexible.

ELLEN STONE

STONE: Some learning problems are a result of developmental lag. And you...

MERROW: Developmental lag meaning you're growing more slowly.

STONE: Right. Right. You may get to the same stages that a child got six months. Well, when you figure that you're in school and you're all supposed to be doing things at the same rate, it can make a big difference.

MERROW: So maybe the school needs to be more flexible.

STONE: Yes. I find this right now. My child, I think, could achieve fine. He could achieve with very little difficulty if there were adaptations that were made, if they were understanding that some children learn slower. Some children learn through a different medium. If they have a visual perceptive problem, use the auditory track. But when they are presented things -- writing on the board, or with many of the printed matter that is undiscernible -- and when their tests are given all through a written test with printed, and the children do not conceptualize these words, they may know the information, it's that they cannot give it to them in the way that the teacher is asking.

MERROW: But that's part of the test. Give me the information the way I'm asking it. You sound like you're saying that these kids are being treated unfairly on the test.

STONE: I think you need to find out...you're asking...is the teacher asking, "Do you know information..." are you teaching information, or are you teaching them to give it to you only in the way that they want it given?

MERROW: The people who belong to the local chapters, are they people like you who...with a child with a problem?

STONE: I think the people who come to the meetings are very genuinely concerned. We do find there are many more women that come than men. I think it's very difficult, many times, for the fathers to accept this. They feel as if it couldn't be my fault, you know; it's yours. And, again, this presents a very difficult emotional problem for the child. And I think we are finding out from learning disabled people, young adults who have grown up with this. From "Time Out To Enjoy," which was at the Illinois State Convention, they said one of the big....

MERROW: That's the adult learning disabled group.

STONE: Yes. The adult learning disabled group. They said, "Don't forget to enjoy us." And it comes across again, "Remember to love us." And I think this is difficult. And my own feeling, I think, sometimes the children and the adults present the problem that wrong is bad. And you know, how could that be? And if you don't understand it, you're dumb, and dumb is terrible; there's nothing worse. And you find out from so many...hearing many of these young adults: they con; they will lie; they'll do anything to cover this up. And if we can come to the understanding that each of us is different. We have talents; we have abilities. And the fact that I have different abilities from you does not make me less of a person. It just means I operate differently.

MERROW: Ellen Stone, President of the Learning Disabilities Association in Naperville, Illinois.

BLAIR: She mentioned the emotional problems that learning disabled children develop and carry with them into adulthood. "Time out for Joy" is a new national organization of learning disabled adults. It takes its name from the unpopular phrase "time out," used in school to describe a room where unruly children are sent -- the "time out" room -- to be isolated and punished.

MERROW: Diane Ridenhour is 30 years old, a college graduate from Oak Park, Illinois. She reads, writes and spells at the third grade level.

BLAIR: She got through George Williams College by using tape recorders and dictation equipment. Today, she's working on a master's degree in social work.

MERROW: Her learning disability, however, created problems all through school.

A 30-YEAR-OLD TALKS ABOUT HER LEARNING DISABILITY

RIDENHOUR: Dumb, I thought I was dumb, or lazy, or crazy, or retarded. And kids would call me dummy, and especially girls. I mean, little hyperactive girls aren't supposed to be in classrooms, especially if they're little and cute, you know. They want to put us out in the hall, or, you know, girls aren't supposed to squirm around in their seats. They're supposed to be neat and good readers and good spellers, and that sort of thing, and lousy at mathematics. Well, I was kind of mediocrely good at mathematics and couldn't sit in my seat.

MERROW: And you couldn't read or write.

RIDENHOUR: And I couldn't read or write. No.

MERROW: So what did you do instead of reading and writing, when every-

body else was reading and writing?

RIDENHOUR: I moved around a lot, or my pencil would fall off my desk, or I'd try real hard to do what I was supposed to do.

MERROW: Are we talking now about all school -- I mean, junior high school, high school and elementary school? You did all those things?

RIDENHOUR: That's right. All the way through school. But I also became real withdrawn and scared of people. By the time I was a senior in high school I couldn't take it anymore. I was placed in a class for emotionally disturbed kids at a state hospital.

MERROW: Maybe you were emotionally disturbed.

RIDENHOUR: By that time? I think I was, by that time. I was angry, hurt, withdrawn, scared.

MERROW: How did you graduate from high school?

RIDENHOUR: I graduated...well, I'd start...the last semester I was in school I was in this school for emotionally disturbed kids, and they gave me a regular diploma when I finished. So that's how I graduated, basically. They didn't...you know, it's like they didn't know what was wrong with me. They gave me tutoring, phonetic tutoring, like I had ten years of remediation in phonetics, and all that kind of stuff. And by the time I got to be a senior in high school, I thought, you know, all had failed. What could I do, you know? I could get married, which I didn't really want to do at that point, or find a job. And the job market wasn't open. There was nothing I could do, you know. I wanted to be something, or do something, you know. And there was nothing there. It felt like the end of the rope was my senior year.

MERROW: Did you grow to hate your own self?

RIDENHOUR: Yeah. Yeah. I did a lot of...at times I think I still do that a little bit, you know. Where I just really get angry and say, "I'm dumb, I'm stupid, I can't do anything right." And then I couldn't figure out...I knew I was smart, but I didn't know I was smart, cause everybody else was yelling at me that I was bad. And I got a lot of bad feelings about me, and hating myself.

MERROW: In the course of going through elementary, junior high and high school...I don't know how many teachers you had. I'd want to guess 40-50. Did any of them respond to you and recognize your problem?

RIDENHOUR: Yes. I had a physical education teacher who was also a science teacher of mine who decided that maybe she could help me. And one way she might be able to help me is to read my...get somebody to read my examinations to me in seventh grade. The problem with that was that she forgot to read my book to me, and no one took the notes for me. So it was like I got the same grade on the test that I would have gotten if I read it myself. Because that's how much information I had. And they also, in high school, set me up with a buddy, where the person was sitting in front of me, and I could ask them what I was reading. But what they forgot again was that I was supposed to ask him one word, and if I really utilized that buddy, the buddy would never get any work done. So I would just, you know, every once in a while ask for some help from her. I wouldn't utilize her. I got kind of scared of that.

MERROW: Are there many people, you adults -- you're 30 years old -- like you walking around?

RIDENHOUR: My guess is there's probably 10% of the population that's... maybe not as severe like me, but there are a lot of people out there walking around that are learning disabled -- can't read or write.

MERROW: But can do other things well.

RIDENHOUR: That's right.

MERROW: Cause there may be a lot of people walking around who can't read or write, or can't do numbers, and can't do much, who aren't very smart.

RIDENHOUR: Right. Well that could be true, you know. But there's certainly people like myself out there too, who can do a lot of things. They may be your local car mechanic, and a super mechanic, you know. But they know they can't read or write. They're feeling retarded and crazy. Or they're in a mental hospital, because they're just given up. And they're sitting on a back ward some place, and they said, "That's it. I can't stand it any longer." Or they get angry at society, and gone out and robbed a bank, or stole a car.

MERROW: Diane Ridenhour, a 30-year-old, who reads, writes and spells at the third grade level. She's now working on a master's degree.

BLAIR: But her disability won't be behind her when she gets the degree. She needs help, for example, when she wants to write a check, or fill out a form.

MERROW: Imagine asking the person next to you in the checkout line to write out your check for you, or to help you make change.

BLAIR: People would probably stare and think you're crazy.

MERROW: Diane Ridenhour says that some learning disabled teenagers end up robbing banks or stealing cars.

BLAIR: Dr. Chester Poremba agrees. He thinks there's a strong link between learning disabilities and juvenile delinquency.

THE RELATIONSHIP BETWEEN LEARNING DISABILITIES AND JUVENILE DELINQUENCY

MERROW: The question is: is every juvenile delinquent learning disabled?

POREMBA: Ninety percent are. That doesn't mean that every learning disabled kid is going to become a delinquent. But what it means is that studies are showing that some place between 75 and 90% of the kids who end up in the delinquency area have learning disabilities.

MERROW: Most juvenile delinquents have learning disabilities, but most learning disabled kids are not juvenile delinquents.

POREMBA: I don't know about most, but it doesn't follow...one doesn't follow. In other words, because you have a learning disability isn't going to make you a delinquent. However, if you're a delinquent, chances are very high you also have had learning disabilities in your past.

MERROW: Let's end on juvenile delinquency. If you have a juvenile delinquent, I'm guessing you'd say, "Look for the learning disability."

POREMBA: That's right. Look for the learning disability, because he has one probably. But also, look for his strengths, and build on his strengths, and, you know, teach him, or let him experience success and not failure. We guarantee their failure, not their successes. So, philosophically I would say look for the strength and build on that.

BLAIR: Dr. Chester Poremba of the Children's Hospital in Denver, Colorado. He says accentuate the positive, which is good advice for working with children, whether they're learning disabled, juvenile delinquents, or just normal kids.

MERROW: Positive reinforcement might be a good start, but it's often not enough, especially in cases of hyperactivity, which is not strictly speaking a learning disability, but is often confused with learning disability.

BLAIR: Not all hyperactive children are learning disabled, and not all learning disabled children are hyperactive. But, there's enough of an

overlap for doctors and teachers and parents to link the two, and to argue about the causes of hyperactivity and the best means to treat it.

MERROW: For instance, how active is hyperactive? What about students who can't sit still for very long, or who constantly interrupt their teachers with questions and comments?

BLAIR: Perhaps our use of the word hyperactivity is too colloquial, and only a doctor can define it adequately. Dr. Keith Connors describes how you can detect hyperactivity by just looking at kids.

WHAT IS HYPERACTIVITY?

CONNORS: On the behavioral, purely behavioral side, you have the child being impulsive. He rushes in where angels fear to tread. He leaps before he looks. He's often running off at the mouth as well as with his feet. He can't control himself, and it's the inappropriate activity that's most clear. Sometimes, it's excessive activity level, but most often it's inappropriately directed activity. He punches when he shouldn't. He restrains himself when he shouldn't. So, it's the poorly modulated, poorly regulated behavior. That's one side. The other side is his attention. He...his attention darts from one thing to another. He can't sustain his attention long enough on a task to be effective at it. He's easily disrupted by external sensory inputs. So, you have an attentional disorder and an impulse disorder. I would reserve the term "hyperactive behavior" disorder, or "hyperkinetic behavior" disorder as a medical term, one where the child has been medically diagnosed, based on a full history and a direct examination of the child and the family. Now, a kid who is simply overactive according to the parents, because the parents have inappropriate standards and inappropriate methods of handling, I would prefer to call a behavior problem, or a defiance problem.

MERROW: But there is the medical phenomenon of hyperactivity, where children just are...their motors are running at a much, much faster rate. That's a very real phenomenon, you're saying.

CONNORS: Yes. There's no question. There are a number of indicators of biological defect. We have genetic evidence to show that not only is this a familial problem, but a genetic problem.

BLAIR: Dr. Keith Connors of the University of Pittsburgh.

MERROW: Biological and genetic theories are only one way to explain why kids are hyperactive. A less complex way is to look at what they put in their mouths.

BLAIR: The "Feingold theory" is that artificial flavorings, artificial colorings, and certain preservatives -- like BHT -- make kids hyperactive.

MERROW: The theory originated with Dr. Benjamin Feingold, who recommends that to treat hyperactivity, we don't need drugs. We just need a change of diet.

BLAIR: The "Feingold theory" has become the "Feingold doctrine" for many people, including Joan Levy, President of the Feingold Association of northern Illinois.

THE 'FEINGOLD TREATMENT' FOR HYPERACTIVITY

LEVY: We had looked for help for 15 years. Our son had been on all kinds of medications: anti-depressants, anti-convulsives, amphetamines--which is "speed; it reverses on a hyperactive child -- sedatives. Our son committed himself to a psychiatric hospital in 1976 -- in the fall -- because he didn't want to go on living. Three months later -- and $12,000 later -- we were told he was not psychotic. And at that time, we were offered no suggestions or solutions. It was at this time that we put our son on the "Feingold diet," with his cooperation. He was very hyperactive. When he went on the diet, he was very depressed. He had the desire to get even with the world for being mis-

handled over 15 years and not being able to find any answers, not getting the help from the school. In three days, he responded totally to "Feingold diet." He began to walk; the depression left, and he didn't have the drive that he used to have that got him in so much trouble with the police and the courts and the jails. And I know that if it were not for the "Feingold diet," our son would be in prison today. I have no doubt.

MERROW: Is it hard to stay on the diet? I mean, an awful lot of that stuff in the food.

LEVY: Well, the "Feingold diet" is a way of life. It shouldn't be so strange to realize that an additive is a chemical and, therefore, can make a child hyperactive. Now, in the children that do not respond to the "Feingold diet," we look for food allergies, and sometimes a sensitivity to sugar. In most cases, we haven't found sugar to be a problem with the hyperactive child. I know that's different than most...the way most other professionals feel.

MERROW: You said the "Feingold diet" is a way of life. It's kind of a religion too. I mean, you're kind of a...you're shaking your head in agreement.

LEVY: Yes, you get to be fanatic.

MERROW: Does that bother you? I mean, does it bother you that maybe people are being led into a crusade, when it really might not help their hyperactive kids?

LEVY: The way we feel about it is we're not hurting those children. The doctors by giving drugs that assault the nervous system can hurt the child. We cannot hurt that child.

MERROW: Missing his "Twinkies" and "Coke" is not going to hurt.

LEVY: Right. By eating better, how can we possibly hurt that child? But the use of medication that doctors try...one and try another. I know that our son was overdosed in the hospital and was causing trouble with the liver. Now, the "Feingold diet" is not going to cause you liver trouble.

MERROW: No. But here's what it might do. It might make me...let's say, I have a hyperactive child. It might make me think Aha, this will solve the problems; therefore, I don't need to worry about looking for other solutions. I've got the "Feingold diet," when in fact, the "Feingold diet" might not work and I would have put off looking for other solutions that would help my kid.

LEVY: There are no other solutions.

MERROW: Joan Levy, President of the Feingold Association, Northern Illinois.

BLAIR: The "Feingold theory" sounds so reasonable. Even if it does nothing to cure hyperactivity, it certainly must be healthier to munch on a carrot than a candy bar.

MERROW: But rather than take for granted his claims about the harmful affects of food additives, researchers are testing Feingold's theories, and they're finding that the evidence in the laboratory is not quite so definitive.

BLAIR: Dr. Keith Connors explains some of the difficulties of testing hyperactive kids scientifically.

<u>DIFFICULTY IN PROVING THE SCIENTIFIC VALUE OF 'FEINGOLD TREATMENT'</u>

CONNORS: It's very difficult to find a cohort of kids who stay on the diet, and who continue to be improved. However, we have done some two-year followups, and we do have a very small group who have stayed on the diet, and who do remain improved. Now, that's not a controlled observation, again, because all the kids who didn't stay on the diet have now vanished. But it's

likely that most of the change observed by Feingold was placebo effect -- non-specific, having nothing to do with the diets.

Now, that doesn't mean that there was nothing to what he said, however. Because when you look within that group who improved, if you take them and now subject them to...you keep them on the diet and you test them in a double blind fashion -- that is...that means that we feed the kids some artificial colors, but he doesn't know when he's getting it, and we don't know he's getting it, so it's blind to both him and to us, and to the parent of course. When you do that, you discover that the kids do get worse during the periods when they get the food coloring, rather than the placebo coloring. They do get worse, but it's a small, small number.

MERROW: Let's rely on your scientific background and...but then let's draw some reasonable conclusions -- conclusions that reasonable people can live with. Should I allow my kids to eat foods with artificial colors and artificial flavors?

CONNORS: Well, I think the point is this. If there's any evidence whatsoever that this does any harm to even a very small number of kids, that it may be doing more harm that we're not aware of and can't detect with our rather crude methods. So, I would say, being a prudent person, a prudent parent, I would, as far as possible, minimize the eating of any kind of junk or chemical.

MERROW: So, you could treat a hyperactive child by taking something away from him -- like certain kinds of food -- or you can give him something -- like certain kinds of drugs.

BLAIR: Dr. Connors sees drug therapy as a proper treatment for children who are truly medically hyperactive, and he lists some of the drugs that doctors now prescribe.

CONNORS: Ritalin is probably the most frequently used. Dexedrine is the next most frequently used.

MERROW: Those are both "uppers."

CONNORS: That's correct, and this is one of the things which has provided the most interesting research topic in the area: why an "upper" should lead to greater control, as it were, in the child? This is a complicated story, but basically, these drugs enhance the activity of central nervous system function. They stimulate; they are neurotransmitter related chemicals. They mimic the activity of naturally occurring transmitters in the brain. And probably what they do is to enhance those functions that lead to greater control, or to greater attentiveness.

MERROW: So the "upper" will calm the kid down, and the kid -- he most likely -- will then be able to pay attention and participate in school as expected.

CONNORS: That's correct. They lead to a greater degree of control over attention and impulse, just as appropriate management leads to greater control over impulse and attention.

MERROW: What percentage of the kids in this country are: one, hyperactive; and two, treated biologically with drugs?

CONNORS: The true incidence, or prevalence rather of this disorder runs around 3.2%, as I recall. The percent of those kids who are actually being treated at any given moment in time by drug treatment is something like .2%. So that...I believe those are the correct figures. I may be a little off. But there's a fairly sizeable discrepency between the number actually identifiable, and the number actually being treated. So, if anything, these kids are undertreated.

BLAIR: Dr. Keith Connors of the University of Pittsburgh. What we

should do about hyperactive kids who disrupt classrooms is highly debatable. Do we give them drugs? Put them in special classes? Or try behavior modification?

MERROW: Although there's a lot of argument about what works, it makes a lot of sense to a lot of experts to start by changing the diet.

THE NEED TO CHANGE THE AMERICAN DIET

SMITH: My wife and I were in Norway, not...well, a couple of years ago, and we asked them, "What do they do with hyperactive kids?" They say, "We don't have them." And then we think we find out why; the Norwegian Government gives every kid that goes to school a piece of cheese and a piece of fish. Our government gives the kids sugar, white flour, chocolate mike. Puts them right on the floor.

BLAIR: Lenden Smith is a medical doctor in Portland, Oregon, who believes that we can substantially reduce the number of hyperactive kids by changing their eating habits. He recommends a diet for all of us.

SMITH: The whole world should do this. It's the gorilla diet. They're supposed to eat raw vegetables as much as possible -- just steam them, or the Chinese wok method. We're into seeds and nuts, and fruit is ok if you have some protein with it. Cheese is ok. We're trying to get away from beef. We want them to eat more chicken and fish. Eggs...

MERROW: You're going to sit here in Kansas City and say, "No more beef"?

SMITH: No more beef, or cut it down. Maybe have only 2 ounces every couple of weeks, or something. We really eat too much beef. And there's one problem with that: we're eating a lot of beef, and it's got a lot of phosphorus, and phosphorus pushes the calcium out of the system. And even though they're drinking milk, these kids we found -- most of them -- are low in calcium. And the calcium is what it takes to keep you calm. So, we give them extra dolemite or limestone. You have a lot of limestone around here, so we could dig that up and save the steers. But it is...the trouble with beef is that it's...the fat is in the interstices of the muscle, and it's hard to get rid of that. They've also found, I'm sorry to announce that vegetarians -- or at least non-beef eaters -- have a lot less cancer, a lot less hypertension. So we really are supposed to eat these other things. But the main thing is no sugar, no white flour, no box cereal at all, and no ice cream, no junk, nothing. "Campbell's Soup" is out. Don't eat "Skippy," "Jif" or "Peter Pan"; their peanut butter...they're so bad. No Jellos, no desserts. A dessert would be some raisins, and maybe some nuts together, or dipping celery sticks into old-fashioned peanut butter, and nibbling on that. We've got to change people's diet. We're killing each other with this.

BLAIR: Dr. Lenden Smith, suggesting one way of treating hyperactivity: through control of diet.

MERROW: Although hyperactivity is not, by strict definition, a learning disability, it provokes the same kinds of questions and controversy.

* * *

BLAIR: If you want to know more about learning disabilities, the transcript of this two-part series contains a list of books and articles on the subject.

MERROW: Here's how to get the transcripts.

BLAIR: Send $1.00 to National Public Radio -- Education, Washington, D.C. 20036. And tell us you want the "Learning Disabilities" transcripts.

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BLAIR: Material for this program came in part from Barbara Bernhard, station WUNC, Chapel Hill, North Carolina; and Cathy Lewis, WXXI, Rochester, New York; and Dan Mack in New York City.

* * *

STUDENT: I...watched...the...shark...

HOWARTH: You're guessing. I'm going to punch you the next time you guess. Come on. PH says what?

STUDENT: Nnn...

HOWARTH: What's the H say?

STUDENT: Cchh.

HOWARTH: All right. What's short U say?

STUDENT: Uh.

HOWARTH: N say?

STUDENT: Nnn.

HOWARTH: What have you got so far?

STUDENT: Shuh-in...

HOWARTH: No, you don't have shh. You have what? What's CH say?

STUDENT: Sshh.

HOWARTH: What's the H say? Model T.

STUDENT: Cchh.

HOWARTH: Don't say anything else. Look up here. What's that say?

STUDENT: Cchh.

HOWARTH: What's that say?

STUDENT: Cchh.

HOWARTH: What does this say?

STUDENT: Sshh.

HOWARTH: What does that say?

STUDENT: Cchh.

HOWARTH: Ok. Short U.

STUDENT: Uh.

STUDENT: Ch-uh.

HOWARTH: Good. Chuh. Just keep that in mind. Chuuuuh...

STUDENT: Chuuuuuh...chun...

HOWARTH: Chuuuuuun-k.

STUDENT: Chunk!

HOWARTH: Beautiful!

* * *

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BLAIR: OPTIONS IN EDUCATION is written and produced by John Merrow. The Associate Producer is Katharine Ferguson. The Assistant Producer is Natalie Iglitz. Technical assistance for this program by Bob Nock and Al Freedman. I'm Wendy Blair.

MERROW: I'm John Merrow, and this is NPR--National Public Radio.

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MUSIC CREDIT: Claude Bolling and Alexandre Lagoya, "Concerto for Classic Guitar and Jazz Piano," RCA FRL-0149

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